State of California—Health and Human Services Agency
Department of Health Services

California
Department of
Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date: June 23, 2004

Dear LEA Provider:

The purpose of this letter is to communicate both the status of Senate Bill 231 (Stats. 2001, Chapter 655, Section 2) implementation, as well as recent federal clarification from the Centers for Medicare and Medicaid Services (CMS) regarding free care and other health coverage requirements and billing for state mandated health assessments.

The Department of Health Services (DHS) has been working closely with an ad-hoc workgroup comprised of representative school districts, county offices of education, the California Department of Education and others to:

- Update existing reimbursement rates paid under the Local Educational Agency (LEA) Medi-Cal Billing Option program;
- Expand reimbursable LEA services;
- Clarify state and federal requirements;
- Improve communication regarding LEA issues, and
- Expand relevant training.

DHS has made solid progress in many of these areas. For example, an outside consulting firm (Tucker Alan Inc./Navigant Consulting, Inc.) was commissioned by DHS to implement an LEA rate study to update treatment rates and develop Individual Education Plan (IEP)/Individual Family Support Plan assessment rates. DHS is currently working with CMS to secure approval of the State Plan Amendment (SPA) 03-024, which was submitted in June 2003 (upon approval, effective as of April 1, 2003). During a conference call on March 24, 2004, CMS raised the following concerns with regard to this SPA:

1. CMS said that DHS must instruct the LEAs that other health coverage information must be sought from 100% of the students and that DHS must enforce the free care policy by means of oversight, training, audits, etc.

2. CMS said that DHS must reconcile certified public expenditures to the actual costs of each individual provider.

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The approval of this SPA is being delayed until these two issues are resolved. Additional Targeted Case Management rates have been developed that will be included in a second SPA to be submitted subsequent to the first SPA's approval.
DHS has also implemented a series of statewide training sessions related to billing, documentation, and free care and other health coverage requirements. One product of these training sessions is an extensive list of questions. DHS is in the process of developing answers to these questions, and will ultimately post them on the DHS LEA website.

Finally, DHS is working on material for other future SPAs, which are intended to expand reimbursable LEA services such as specialized transportation, personal care, therapy assistants, and others.

At DHS's request, CMS has formally clarified the federal interpretation of some LEA issues. Specifically, CMS has determined that LEA providers must adhere to strict billing procedures regarding free care and other health coverage issues. CMS interprets its free care policy to mean that providers, including LEAs, cannot be reimbursed for services furnished to Medi-Cal beneficiaries if the same services are provided free of charge to non-Medi-Cal beneficiaries. (State Medicaid Manual, section 5340.) According to CMS, state mandated health assessments, including vision and hearing, cannot be billed to the Medi-Cal program (See attached letter from CMS to Stan Rosenstein, dated April 14, 2004).

During a conference call on March 24, 2004, CMS stated that LEAs must receive 100% response when obtaining other health coverage information. Many LEAs have reported to DHS that it is impossible to be in full compliance with these requirements. Anticipating a possible audit, many of these LEAs have chosen not to bill for non-IEP services. LEA services are covered and reimbursable only to the extent that federal financial participation is available. (Welfare & Institution Code section 14132.06.) It is the responsibility of every LEA to follow federal billing guidelines in their program. Failure to comply with CMS requirements regarding free care and third party liability could result in an audit disallowance or recovery of payment made to the LEA.

Sincerely,

Original signed by Stan Rosenstein

Stan Rosenstein
Deputy Director
Medical Care Services

Enclosure

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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APR 14 2004

Stan Rosenstein, Deputy Director
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Dear Mr. Rosenstein:

You requested clarification of the free care requirements from the Centers for Medicare & Medicaid Services (CMS). Your request came up in the context of discussing local education agency (LEA) services provided to children who do not have an IEP/IFSP.

CMS has provided information on the free care in several issuances. Section 5340 of the State Medicaid Manual describes the conditions that must be met if Medicaid is to be billed for medical services. These conditions have also been described in the Medicaid and School Health: A Technical Assistance Guide and were reiterated in the "Medicaid and School-Based Administrative Claiming Guide," published on May 28, 2003. Enclosed are the pertinent pages excerpted from both of these guides.

Free care services are services for which there is no beneficiary liability. In the context of schools, these include routine vision and hearing screenings, head lice screenings, and other care provided by a school nurse. This precludes Medicaid from reimbursing for the costs of Medicaid-coverable services that are generally available to all students without charge, and for which no other sources for reimbursement are pursued. Medicaid will **not** pay for any services not specified in a child's IEP or IFSP, if the same service is provided free of charge to non-Medicaid children in the school. In order for Medicaid payment to be available for these services, the provider must:

1) establish a fee for each service that is available;
2) *ascertain whether every individual served by the provider has any third party benefits*; and
3) bill other responsible third party insurers.

While federal legislation provides for exceptions to the above-stated policy with regard to services provided under IDEA, the Women, Infants and Children's (WIC) program and

services provided by title V grantees, many schools provide a wide range of health services that would not fall under these exceptions. Also, any medical services that are provided to Medicaid children pursuant to an individualized service plan under section 504 of the Rehabilitation Act of 1973 are the legal responsibility of the LEA and may not be reimbursed by Medicaid.

We understand that the free care provision serves to limit the ability of schools to bill Medicaid for covered services provided to Medicaid-eligible children because schools that provide needed health services often provide them to all students free of charge. Because issues have arisen regarding how these requirements could be put into practice in a school setting, we offer one way that this can be operationalized. For services not included in an IEP or IFSP, an LEA may bill Medicaid only if the LEA, as the provider of services, obtains health insurance information for each student (Medicaid or non-Medicaid) prior to providing the service and bills all liable third parties. If LEAs provide LEA services to any child for whom they have no TPL information, the LEA is providing free care and Medicaid cannot be billed.

Once all third party insurers have been identified, they should be billed for the services. However, third party pursuit would not be necessary if there is clear and convincing documentation of non-coverage by other insurers. Documenting non-coverage may be done through the use of a survey of all of the third party insurers providing coverage for children served by the LEA. The survey should specify the procedure codes in question and confirm that the scope of benefits provided by the surveyed insurers does not cover the specified procedures. Alternately, insurers could be billed to obtain documentation of non-coverage, which could be used as a precedent so that future claims need not be submitted to that insurer. This procedure must be performed on an annual basis. A precedent file must be maintained to document the non-coverage of all LEA services by insurers. This must be available for audit and review.

Sincerely,

Linda Minamoto
Associate Regional Administrator
Division of Medicaid & Children's Health

Enclosures: Medicaid and School Health: A Technical Assistance Guide
http://www.cms.hhs.gov/medicaid/schools/scbintro.asp
Medicaid and School-Based Administrative Claiming Guide
http://www.cms.hhs.gov/medicaid/schools/clmguide.asp
State Medicaid Manual Section 5340

5340. REIMBURSEMENT

A. General Information.--Any service provided to EPSDT eligibles covered under the EPSDT program may be reimbursed under Medicaid, even if it is mandated by another agency or available as a community health service.

Medicaid provides financial access to health care services for individuals determined unable to pay for them, assures availability and delivery of EPSDT services, provides or arranges for covered services, and pays for them unless the beneficiary has liable third party coverage or the services are provided free of charge. Third party resources include Medicare (title XVIII), Railroad Retirement Act, insurance policies (private health, group health, liability, automobile, or family health insurance carried by an absent parent), Workers' Compensation, Veterans Administration Benefits, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Except for title V services, it is Medicaid policy that services which are available without charge to all individuals in the community may not be reimbursed. Services without charge, for purposes of Medicaid, means that no individual or family is charged for medical care and third party reimbursement is not sought.

The law requires the provision of the services needed by EPSDT clients *if the services can be covered under the Medicaid program. Coordination of services* to maximize treatment of clients is an essential aspect of the EPSDT program. Therefore, programs which enter into written interagency and/or provider agreements with the Medicaid agency to provide a service mandated on that agency, must specify the terms of reimbursement in such agreements.

The following conditions must be met if Medicaid is to be billed for medical services provided by other agencies or programs financed by Federal and State funds:

o A fee schedule is established for each service billed to Medicaid; and

o Information on third party liable resources is obtained from each Medicaid beneficiary, and billing of all third party liable resources is documented.

B. Services.--Provide payment for screening, vision, hearing, and dental services as well as for other health care, diagnostic, treatment, or other measures which are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Provide payment for diagnosis and treatment services and continuing medical treatment after an initial referral if medically necessary.

Agreements with other agencies, such as title V grantees, may provide for payment mechanisms that are used for other providers, including the Medicaid fee schedule and reasonable charge structures. Limit reimbursement of overhead costs under interagency agreements to costs identifiable as supporting EPSDT Medicaid services.

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

May 2003

The required elements of public assistance CAPs are further discussed in the Cost Allocation Plan section of the Guide (Section V., D.), as is the review and approval process for such plans.

12. Free Care

The "free care" principle precludes Medicaid from paying for the costs of Medicaid-coverable services and activities which are generally available to all students without charge, and for which no other sources for reimbursement are pursued. Thus, Medicaid cannot reimburse for routine school-based vision and hearing screenings or other primary and preventive services provided free of charge to all students. In order for Medicaid payment to be available for these services, the provider must:

1) establish a fee for each service that is available;
2) collect third party insurance information from all those served (Medicaid and non-Medicaid); and
3) bill other responsible third party insurers.

Federal legislation provides for exceptions to the above-stated policy with regard to services provided under IDEA, the Women, Infants and Children's (WIC) program and services provided by title V grantees. Thus, Medicaid will pay before the education agency, the WIC program, or title V for Medicaid coverable services provided by those programs to Medicaid eligible children. This is true whether or not the IDEA, WIC or title V provider also charges non-Medicaid beneficiaries of these services. With respect to the title V exception, Medicaid will only reimburse for Medicaid-covered services provided to Medicaid beneficiaries to the extent that title V funds are used or available to the title V provider to provide the services. To the extent that the provider receives other, non-title V funds to provide the services, the title V exception from free care and third party liability does not apply.

The exceptions to the free care and payor of last resort principles are specified in Medicaid statute:

> Section 1902(a)(11)(B) of the Act (42 U.S.C. 1396a(a)(11)(B)), which provides for Medicaid to pay for Medicaid coverable services provided by a Title V grantee in the state.
>
> Section 1903(c) of the Act (42 U.S.C. 1396b(c)), which allows Medicaid to pay for coverable Medicaid services for children that are included in an IEP or Individualized Family Service Plan (IFSP) under the IDEA.

Medicaid will **not** pay for "EPSDT-type" primary and preventive care services not specified in a child's IEP, if the same service is provided free of charge to non-Medicaid children in the school. For example, the services of a school nurse who attends to a Medicaid child's sore throat, sprained ankle, or other acute medical problem **cannot** be reimbursed by Medicaid if similar services provided by the nurse to non-Medicaid children are not billed. Also, Medicaid coverable medical services that are provided to Medicaid children under a "section 504 plan" in order to make education accessible to these children with disabilities, are not reimbursed by Medicaid. It is the responsibility of the education agency to provide these services, and other third-party payors are not generally billed for these services. Costs of related administrative activities for these services are also not allowable under Medicaid.

Medical services specified in a child's IEP, and administrative activities provided in support of those services are treated differently from the other EPSDT-type primary and preventive services or "section 504 plan" services discussed above. Medicaid, as required by 1903(c) of the Act, will pay for IEP-specified medical services and related administrative costs provided to Medicaid children, even though non-Medicaid children are generally not billed for them.

This Guide does not change existing third party liability (TPL) requirements for IEP services. Medicaid is primary payor to the education agency for services included in an IEP, but is secondary to any other payor. Medicaid TPL provisions for pursuing all other sources of liability are still required by statute (section 1902(a)(25)(E) of the Act, 42 U.S.C. 1396a(a)(25)(E)) and recovery is sought if there is a liable third party (See also Section VI., J.).

> Example: A screening is provided free of charge to all students. Medicaid would not pay for the screen since it falls under the free care provision. However, the screening may lead to the discovery of a needed service included in a Medicaid enrolled child's IEP. In such a case, Medicaid could pay for the medically necessary service discovered through the screen (assuming the service is not considered free care). Medicaid distinguishes between the screening and the medically necessary service discovered through the screen because the school does not bill any third parties for the provision of the free screening while it does bill for the medical service. The free care provision applies to the particular service in question, and, for this reason, the screening and the service are treated differently for purposes of FFP. Medicaid by law is responsible for paying for the medically necessary services in IEPs, as well as the related administrative activities (i.e., the referral).

We understand that the free care provision serves to limit the ability of schools to bill Medicaid for covered services provided to Medicaid-eligible children because schools that provide needed health services often provide them to all students free of charge. While there are exceptions to the free care principle for Title V and Medicaid services provided to children with disabilities pursuant to an IEP under IDEA, many schools provide a range of services that would not fall under these exceptions, including services provided by school nurses and school psychologists.

The free care principle is relevant to the construction of time study activity codes. To the extent that a medical service is not reimbursable under the Medicaid program due to the free care policy, associated administrative costs also may not be claimed. For example, state laws may require that immunizations be provided to all school children, regardless of the child's income status or whether the child is Medicaid eligible. In such a case the administrative activities related to assisting the child to obtain such immunizations in the school would not be reimbursable as a Medicaid administrative cost. Therefore, such an activity would be reported under Code 9.a., not 9.b., based on the model activity code system in Section IV., C.

C. Activity Codes: Descriptions and Examples

1. Introduction

When staff perform duties related to the proper administration of the state's Medicaid program, federal funds may be drawn as federal financial participation (FFP) for the costs of providing these

MEDICAID AND SCHOOL HEALTH: A TECHNICAL ASSISTANCE GUIDE

August 1997

This guide contains specific technical information on the Medicaid requirements associated with seeking payment for coverable services rendered in a school-based setting. This document was written before the passage of the Balanced Budget Act of 1997; thus, the information stated herein is reflective of Medicaid statute and policy prior to those new legislative provisions. The information contained in this guide does not have copyright restrictions; school districts are encouraged to share and distribute this information to interested parties. A copy of this guide as well as further information on the Medicaid program can be obtained on the Internet at <<www.hcfa.gov>>.

The Center for Medicaid and State Operations would like to acknowledge the Department of Education, the American Public Welfare Association, the Maternal and Child Health Technical Advisory Group and the HCFA regional offices for assistance in development and dissemination of this guide.

Free Care An important requirement related to billing for Medicaid covered school-based services is the issue of "free care." From the outset of the Medicaid program, a principle basic to public assistance has applied to Title XIX, in that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free care, or services provided without charge, are services for
which there is no beneficiary liability and for which there is no Medicaid liability.

In applying the free care principle to determine whether medical services are provided free of charge and, thus, there is no payment liability to Medicaid, a determination must be made whether both Medicaid and non-Medicaid beneficiaries are charged for the service. Providers of Medicaid services must have the authority to charge for their services and utilize this authority, before Medicaid will make payment. If only Medicaid recipients or their third parties are charged for the service, the care is free and Medicaid will not reimburse for the service.

Schools may employ certain methods to ensure the care is not considered free, allowing Medicaid to be billed. The services would not be considered free if the following conditions are met. The provider:

(1) Establishes a fee schedule for the services provided (it could be sliding scale to accommodate individuals with low income);
(2) Ascertains whether every individual served by the provider has any third-party benefits, and
(3) Bills the beneficiary and/or any third parties for reimbursable services.

Exceptions to Free Care
For purposes of the provision of school-based health services, there are two exceptions to the free care rule, described below.

(1) IDEA. Section 1903(c) of the Act prohibits the Secretary from refusing to pay or otherwise limiting payment for services provided to children with disabilities which are funded under the IDEA under an IEP or IFSP. Under these circumstances, Medicaid is the primary payer to the Department of Education. As such, Medicaid-covered services provided under an IEP or IFSP are exempt from the free care rule. This means that school providers may bill Medicaid for Medicaid-covered services provided to children under IDEA even though they may be provided to non-Medicaid eligible children for free. However, as discussed in more detail below, the requirements to bill all liable third parties for services still

apply. Therefore, although the services would be exempt from the free care rule, the school would still have to pursue any liable third party insurers for reimbursement.

(2) Title V. Another exception to the free care policy which relates to school-based health services includes services provided by Title V of the Social Security Act. Title V of the Act is the Maternal and Child Health Services Block Grant, which provides a lump sum of funds to states for the provision of health services and related activities to mothers, children and adolescents for the reduction of infant mortality, preventable diseases, and access for to necessary health services.

Federal Medicaid regulations at 42 CFR 431.615 define Title V grantees as agencies, institutions, or organizations that receive Federal funding for part or all of
the cost of providing maternal and child health services, services to children with special health care needs, maternal and infant care projects, children and youth projects and projects for the dental health of children under Title V of the Act. Schools may be able to qualify for funding under Title V as grantees, whether they contract with health providers or are a provider themselves. Medicaid regulations specify requirements for cooperative agreements and arrangements between Title V grantees and state Medicaid agencies. Medicaid-covered services provided by Title V are exempt from both the free care rule and the policy of Medicaid as the payer of last resort in that Medicaid will pay before Title V for Medicaid-covered services. Again, although the services would be exempt from the free care rule, the school would still have to pursue any other liable third party insurers for reimbursement before billing Medicaid.

Impact of Free Care on School-Based Health Services

This policy on free care somewhat limits the ability of schools to bill Medicaid for covered services provided to Medicaid eligibles unless the school charges all students for the services provided or meets one of the exceptions above. For example, many schools have a school nurse on staff to provide necessary health services to all students without charging them for the care provided. However, the school cannot charge the Medicaid program for the services of the school nurse, if she furnishes care to all students (not solely Medicaid eligibles) without also charging non-Medicaid students. While there are exceptions to this free care requirement for Title V and Medicaid-covered services provided under the scope of an IEP or IFSP under IDEA, many schools provide a wide range of health services which would not fall under

either exception.